ABC Pediatrics

Authorization by Proxy for Care | 2024

PATIENT NAME	D.O.B.	Male/Female

I hereby state that I am that parent/guardian of the above-named child(ren) and I am legally responsible for making any decisions regarding their medical care. **The caregivers below are my proxy decision makers and are authorized to bring my child(ren) to ABC Pediatrics for medical appointments and treatment and make medical decisions in my absence.** Those named below are adults and legally and medically competent to exercise this authority as delegated and detailed below.

I further authorize ABC Pediatrics to triage or discuss with those designated below, either in person or by phone, my child's symptoms and/or medical condition to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child. This includes releasing relevant protected health information. If for some reason I am unreachable in a situation that occurs that isn't routine, you may rely on the caregiver for consent.

I further authorize the caregivers named below to obtain any medical records/forms/prescriptions from the practice on my behalf. I agree to be financially responsible for all services rendered in my absence. This authorization shall be in effect until revoked, in writing, by me.

THIS FORM SHOULD INCLUDE EVERY PERSON YOU AUTHORIZE TO BRING YOUR CHILD TO THE OFFICE, PICK UP PRESCRIPTIONS, RECORDS, NOTES, ETC. If they are not included they will need something in writing from you in order to proceed with any of your child's needs.

You can list ANY EXCLUSIONS for any of your proxy's.

CAREGIVER's NAME	Relationship	Exclusions to decisions allowed (vaccines, releasing records, etc.)

Notice: Proxy should bring photo ID to the office when they come in for any reason

Parent/Guardian Signature: _____Date: _____

Printed Name: _____